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Material Incorporated by Reference

Clean
MAP-82001 Drug Prior Authorization Request Form
October 18, 2004 Edition

MAP-82101 Brand Name Drug Override Request Form
October 18, 2004

MAP-012802 PPI and H2 Blocker Request Form
October 18, 2004 Edition

Filed: January 28, 2005

First Health
Services Corporation

Drug Prior Authorization Request Form (MAP-82001, revised 10/18/04)

Submitted by: [ ] Prescriber [ ] Pharmacy

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

FAX to **800-365-8835** (toll free)

For **URGENT** Requests Only, FAX to **800-421-9064** (toll free)
For **NURSING FACILITY** Requests Only, FAX to **800-453-2273** (toll free)

MAIL to PA Unit, 14955 Heathrow Forest Pkwy. Houston, TX 77032
Put return address below:

_____

REQUEST TYPE (please check): ☐ **PRIOR AUTHORIZATION** ☐ **MEDICARE PART B OVERRIDE** ☐ **QUANTITY LIMIT OVERRIDE**
☐ **OTHER** _____

RECIPIENT NAME	MAID # (10 digits)	DATE OF BIRTH
	_ _ _ _ _ _ _ _ _ _	

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
State License# (Not DEA# or Any other #)		

	Drug Requested (Use separate form to request more than 4 drugs.)	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA	National Drug Code (if known)
1							
2							
3							
4							

HAS THE REQUESTED DRUG BEEN PRIOR AUTHORIZED PREVIOUSLY? [ ] YES [ ] NO [ ] UNKNOWN

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

_____

MEDICAL JUSTIFICATION (including drugs already tried)_____

_____

_____

MEDICARE PART B REQUEST REASON (PLEASE CHECK ONE): (A copy of the Medicare EOB denying coverage must accompany each request)

☐ RECIPIENT IS NOT MEDICARE PART B ELIGIBLE

☐ RECIPIENT IS TAKING THE MEDICATION FOR AN INDICATION THAT IS NOT COVERED BY MEDICARE

☐ OTHER (PLEASE EXPLAIN ABOVE)

☐ DRUG DOES NOT MEET MEDICARE COVERAGE CRITERIA

	LEAVE THIS SECTION BLANK
DRUG #1	
DRUG #2	
DRUG #3	
DRUG #4	

First Health
Services Corporation

BRAND NAME
DRUG REQUEST FORM
(MAP-82101, revised 10/18/04)

FAX to **800-365-8835** (toll free)

For **URGENT** Requests Only, FAX to **800-421-9064** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **800-453-2273** (toll free)

MAIL to PA Unit, 14955 Heathrow Forest Pkwy. Houston, TX 77032
Put return address below:

_____

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

Use this form to request a brand name drug when generic forms of the drug are available. Please provide medical justification why the individual can not be appropriately treated with the generic form of the drug.

RECIPIENT NAME	MAID #	DATE OF BIRTH
	_ _ _ _ _ _ _ _ _	

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
State License # (Not DEA# or Any other #)		

	Brand Name Drug Requested (Use separate form to request more than 2 drugs.)	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA
1						
2						

	Has patient recently been treated with generic forms of the requested brand name drug? Circle yes or no. Specify dosage and length of therapy with generic forms.	Hand write "Brand Medically Necessary"	Prescriber Signature
1	Yes No		
2	Yes No		

HAS THE REQUESTED DRUG BEEN PRIOR AUTHORIZED PREVIOUSLY? [ ] YES [ ] NO [ ] UNKNOWN

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

_____

MEDICAL JUSTIFICATION (Indicate why the individual's medical condition cannot be adequately treated with generic forms of the drug. Provide any appropriate laboratory tests, blood levels, dates generic drugs prescribed by current/previous providers, or any other medical documents to support the request for the brand name drug.)

***If the patient had an adverse response to the generic form of the drug, have you submitted a MedWatch form to the FDA? If yes, please include a copy with this form.

_____

_____

_____

	LEAVE THIS SECTION BLANK
DRUG #1	
DRUG #2	

First Health
Services Corporation

PPI and H2 BLOCKER Request Form

(MAP-012802, revised 10/18/04)

Submitted by: [ ] Prescriber [ ] Pharmacy

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

FAX to **800-365-8835** (toll free)

For **URGENT** Requests Only, FAX to **800-421-9064** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **800-453-2273** (toll free)

MAIL to PA Unit, 14955 Heathrow Forest Pkwy. Houston, TX 77032
Put return address below:

_____

RECIPIENT NAME	MAID # (10 digits)	DATE OF BIRTH
	_ _ _ _ _ _ _ _ _	

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
State License# (Not DEA# or Any other #)		

	Name of Drug Requested	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA	National Drug Code (if known)
1							

YES	NO	Unknown	
[ ]	[ ]	[ ]	is the request for brand name only (if generic is available)? If yes, prescriber must handwrite *Brand Necessary* & sign beside it: _____
[ ]	[ ]	[ ]	Has the requested drug been prior authorized previously?
[ ]	[ ]	[ ]	Has endoscopy or an esophagram been done? Give date of exam & results: _____ _____
[ ]	[ ]	[ ]	For PPI requests: Is the request for initial or new treatment with a PPI?
[ ]	[ ]	[ ]	For PPI requests: Has the recipient been treated for more than 12 weeks with PPIs during the past 6 months?

DIAGNOSIS (check one)

[ ] Barrett's esophagitis
[ ] Duodenal ulcer, acute or recurring
[ ] Esophageal stricture
[ ] Gastric cancer, current or previous
[ ] Gastric Ulcer, acute or recurring
[ ] GERD (Gastroesophageal Reflux Disease)
[ ] GERD grade III-V, continuing symptomatic
[ ] GERD , atypical with chronic laryngitis, hoarseness, or cough due to reflux
[ ] *Heliobacter pylori* eradication protocol
[ ] NSAID gastropathy
[ ] Scharzki's ring
[ ] Zollinger-Ellison syndrome
[ ] Other (specify) _____

PPI or H2 Blocker Therapy (List all PPIs and H2 blockers used in the past 3 months	Dosage Form	Strength	Directions for Use	Date treatment started	Date treatment ended

CURRENT MEDICATIONS _____

MEDICAL JUSTIFICATION (including drugs already tried)_____

_____

	LEAVE THIS SECTION BLANK